PRELIMINARY DRAFT

Workgroup III: Cardiovascular Disease

The third session of the Arkansas Healthcare Payment Improvement Initiative Cardiovascular Disease Workgroup convened on February 29, 2012 to discuss payment innovation in Arkansas, with an emphasis on episode design for acute and post-acute Congestive Heart Failure (CHF).

Approximately 50 Arkansas healthcare professionals and patients were in attendance at the third workgroup, representing perspectives of providers (e.g., cardiologists, cardiac surgeons, internists, family medicine physicians, pharmacists, nurses), hospital leaders, advocacy groups, public health experts, nonprofit administrators, government officials, and others.

Key components of the discussion from the third workgroup are summarized below. Further materials from this and previous workgroups can be accessed online at <http://humanservices.arkansas.gov/director/Pages/Cardiovascular-Disease-Workgroup.aspx>.

KEY COMPONENTS OF WORKGROUP III DISCUSSION

- The third workgroup session focused on:
  - Discussing version 1.0 episode design elements specific to the acute + post-acute CHF episode (including a focused discussion on quality)
  - Reviewing historical data for the acute + post-acute CHF episode based on version 1.0 design
  - Briefly reviewing cross-episode payment strategies
- The workgroup reviewed key elements from the previous workgroup session in December, with an emphasis on goals of the Payment Improvement Initiative, design elements around "episode performance payments"(previously described as "retrospective reconciliation"), and criteria for selection of principal accountable providers (PAP) across episodes. It further reviewed the expectations around the July 1st launch date, including:
  - The program announcement and education to commence in May/June
  - The program launch date set for July 1st
  - A 3-6 month reporting period to begin on July 1st
  - The feedback period for workgroup feedback and payor refinements on version 1.0 from July 1st through September 1st
  - The performance period launch in Q4 2012 or Q1 2013

- Workgroup members provided input on the overall approach to payment innovation and CHF episode:
  - Workgroup participants raised the importance of reducing initial admissions as well as readmissions, highlighting the importance of chronic management of CHF patients in addition to the acute + post-acute episode design (the focus of the workgroup discussion). Population-based models such as Patient-Centered Medical Homes (a core element of the Payment Improvement Initiative) were mentioned as complementary to episodes in their focus on the management of chronic disease and provision of prevention / wellness care and evidence based medicine.
  - Some workgroup members clarified the definition of readmissions, which similar to the Medicare standard, is defined as all-cause readmissions. Participants further emphasized the importance of increased transparency regarding readmissions to a different hospital than the discharging hospital.
  - The similarity and differences of the CHF episode approach to "closed models" such as VA programs was discussed, acknowledging that the Payment Initiative seeks to encourage clinical integration without prescribing formal, legal integration; and that the Initiative does not intend to restrict patients' freedom to move between different providers of their choosing.
  - Participants highlighted the importance of controlling for case mix differences across providers under the new payment model. Interestingly, however, the group looked at data that displayed little variation in readmission rate by DRG. The group discussed controlling for case mix differences via patient exclusions, along with risk adjustment methodology that would evolve over time to include a greater number of risk factors (e.g., in the long run accounting for "patient shoppers")
- A brief video clip of White River Medical Center's innovative program around monitoring and providing support for CHF patients spurred discussion around successfully extending provider reach beyond the hospital to reduce readmissions. Participants noted that the use of home health services to reduce readmissions appears to be a successful strategy and could be transferable across providers.
- Workgroup members provided important input on specific version 1.0 design elements:
  - *Patient inclusions and exclusions*: Participants raised questions around definitions for clinical exclusions – e.g., patients with ESRD – noting that claims-based identification of such patients is initially preferable to the collection of additional clinical data. Other members raised the possibility of excluding patients with substance abuse issues for both clinical and non-compliance reasons, resulting in plans for future exploration and discussion.

- *Service inclusions and exclusions:* Workgroup members suggested further exploration of pacemakers and other devices given high costs and strong level of clinical evidence associated with these procedures.
- *Principal accountable provider*: Some participants stressed the importance of clearly defining whether transfer patients are included in the episode and, if so, how PAP assignment is handled (agreed to explore in more detail in coming weeks).

- The workgroup discussed quality metrics relevant to the CHF episode, noting that while reducing cost by reducing readmissions is inherently aligned with providing higher quality care, further monitoring or linking reimbursement to quality is warranted for some metrics (e.g., those metrics which are not inherently incentivized within the episode):
  - Members agreed that providing ACE inhibitor or ARB therapy to appropriate patients has strong clinical evidence for long term benefits but may not have significant impact on the outcome of the acute and post-acute CHF episode. There was overall support for the inclusion as a quality metric, but some suggested that since ACE inhibitor or ARB therapy is already administered appropriately by many providers, linking it to reimbursement may not be necessary
  - In addition, some participants suggested monitoring in-hospital and 30-day mortality rates to ensure quality. Similarly, there was discussion on patient experience / satisfaction which will manifest itself through patient choice of provider(s) and in version 2.0 via quality metrics.